

**GENERAL:**

Name \_\_\_\_\_ Date \_\_\_\_\_  
DOB: \_\_\_\_\_ For office use: Account#: \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_ **Time of day:** \_\_\_\_\_

**Location:** Main Street: \_\_\_\_\_ City & State: \_\_\_\_\_

**Were you the:** Driver Passenger Front Back (rt/lt side) Pedestrian

**Number of people in the car?** \_\_\_\_\_

**Did your car strike the other?** Yes No **Did the other car strike yours?** Yes No

**How many impacts were there?** \_\_\_\_\_

**Were you struck from the:** front rear left side right side other

**Which direction were you headed?** N S E W **Other vehicle?** N S E W

**What was your approximate speed?** \_\_\_\_\_ **Other vehicle:** \_\_\_\_\_

**What type of car were you in?** \_\_\_\_\_ **Other vehicle type:** \_\_\_\_\_

**Was your foot on the brake?** Yes No

**Were the roads:** Wet Dry Icy Other

**Were the police notified?** Yes No

**Was your car towed away?** Yes No

**Were you wearing a seat belt?** Yes No **Shoulder strap** Yes No

**Did an air bag stop your body's motion?** Yes No

**Does your car have a headrest?** Yes No

**Height or Position of headrest?** Shoulder Neck Head Above head

**Did you brace for the collision?** Yes No

**Which direction were you looking at the time of impact?** Left right down up straight ahead

**Did your body hit anything in the vehicle?** Yes No **If yes, explain**

**Did you lose consciousness?** Yes No **If yes how long?** \_\_\_\_\_

**What position were your hands on the steering wheel/in the vehicle?** Example.: left: 10:00 right: 2:00

**Left Hand:** \_\_\_\_\_ **Right Hand:** \_\_\_\_\_

**Please briefly describe the accident in your own words:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME: \_\_\_\_\_

**PREVIOUS TREATMENT**

**Were you taken to the hospital? Yes No Which hospital?** \_\_\_\_\_

**What type of treatment did you receive?** \_\_\_\_\_

**Have you seen any doctors since the accident? Yes No Who?** \_\_\_\_\_

**List all treatment since the motor vehicle collision** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list all medication you have taken since the motor vehicle collision:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PREVIOUS HISTORY**

**Did you have any physical complaints BEFORE THE ACCIDENT? Yes No** \_\_\_\_\_

**If yes please describe in detail:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you had any previous auto accidents or any other type of physical injury (work, slips and falls)**

**which required care from a physician? Yes No** \_\_\_\_\_

**If yes please describe in detail:** \_\_\_\_\_

\_\_\_\_\_

**What type of treatment was given?** \_\_\_\_\_

\_\_\_\_\_

**How long was your care?** \_\_\_\_\_

**Were you released from care? Yes No If no, please explain** \_\_\_\_\_

\_\_\_\_\_

**EMPLOYMENT INFORMATION:**

**Who is your employer? Phone#** \_\_\_\_\_

**What is your job description?** \_\_\_\_\_

**Have you missed any time from work since the accident? Yes No** \_\_\_\_\_

**How many days? Are you still off work? Yes No** \_\_\_\_\_

**If working, describe your work capacity:** \_\_\_\_\_

\_\_\_\_\_

**CURRENT CONDITIONS:**

**Describe how you felt:**

**RIGHT after the accident:** \_\_\_\_\_

\_\_\_\_\_

**LATER that day:** \_\_\_\_\_

\_\_\_\_\_

**The NEXT day:** \_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_

**PHYSICAL SYMPTOMS:** Please check any symptoms you have experienced since the accident.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Buttock pain              | <input type="checkbox"/> Loss of balance    |
| <input type="checkbox"/> Skull or head pain        | <input type="checkbox"/> Leg pain (rt/lt)          | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Neck pain                 | <input type="checkbox"/> Leg numbness (rt/lt)      | <input type="checkbox"/> Nausea/Vomiting    |
| <input type="checkbox"/> Neck stiffness            | <input type="checkbox"/> Pins/needles legs (rt/lt) | <b>Difficulty/pain when:</b>                |
| <input type="checkbox"/> Head feels too heavy      | <input type="checkbox"/> Numbness in toes/feet     | <input type="checkbox"/> Riding in car      |
| <input type="checkbox"/> TMJ pain                  | <input type="checkbox"/> Cold feet                 | <input type="checkbox"/> Bending            |
| <input type="checkbox"/> Shoulder pain/stiffness   | <input type="checkbox"/> Depression                | <input type="checkbox"/> Standing           |
| <input type="checkbox"/> Arm pain (rt/lt)          | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Sitting            |
| <input type="checkbox"/> Arm numbness (rt/lt)      | <input type="checkbox"/> Tension                   | <input type="checkbox"/> Walking            |
| <input type="checkbox"/> Pins/needles arms (rt/lt) | <input type="checkbox"/> Irritability              | <input type="checkbox"/> Rising to walk     |
| <input type="checkbox"/> Numbness in hands (rt/lt) | <input type="checkbox"/> Nervousness               | <input type="checkbox"/> Lifting            |
| <input type="checkbox"/> Cold hands                | <input type="checkbox"/> Mental dullness           | <input type="checkbox"/> Twisting           |
| <input type="checkbox"/> Upper back pain/stiffness | <input type="checkbox"/> Loss of memory            | <input type="checkbox"/> House chores       |
| <input type="checkbox"/> Mid back pain/stiffness   | <input type="checkbox"/> Difficulty sleeping       | <input type="checkbox"/> Coughing           |
| <input type="checkbox"/> Chest pains               | <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Sneezing           |
| <input type="checkbox"/> Rib pain                  | <input type="checkbox"/> Difficulty focusing       | <input type="checkbox"/> Driving            |
| <input type="checkbox"/> Painful breathing         | <input type="checkbox"/> Pain behind eyes          | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Lower back pain/stiffness | <input type="checkbox"/> Eyes sensitive to light   | _____                                       |
| <input type="checkbox"/> Hip pain                  | <input type="checkbox"/> Buzzing/Ringing in ears   |   |

Please indicate the amount of pain you are in using this pain scale: 1-minimum, 5-medium, 10-worst pain

1      2      3      4      5      6      7      8      9      10

Please circle the type of pain that you are in (circle all that apply):

Sharp      Dull      Achy      Burning      Heavy      Throbbing

Other: \_\_\_\_\_

**Since this injury occurred, are your symptoms:      improving      getting worse      same**

**Do you notice any activity restrictions as a result of this injury?      Yes      No**

**If yes, please describe in detail:**

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**Other pertinent information:**

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**My signature below indicates that I have answered the above questions to the best of my ability.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

*(For office use only)* ACCT# OR DOI: \_\_\_\_\_